

APPENDIX 4a
BILLING EXAMPLE
NON-TARGETED OUTREACH /COMPREHENSIVE SCREEN WITH IMMUNIZATIONS
CLAIM SORT INDICATOR "H"
RECEIVED BY EDS NO LATER THAN 6/30/95

HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/>				1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A				3. PATIENT'S BIRTH DATE MM DD YY MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>			
5. PATIENT'S ADDRESS (No., Street) 609 Willow St.				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
CITY Anytown		STATE WI		7. INSURED'S ADDRESS (No., Street) 			
ZIP CODE 55555		TELEPHONE (Include Area Code) (XXX) XXX-XXXX		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-Y				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
a. OTHER INSURED'S POLICY OR GROUP NUMBER 				11. INSURED'S POLICY GROUP OR FECA NUMBER 			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> SEX <input type="checkbox"/>				a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> SEX <input type="checkbox"/>			
c. EMPLOYER'S NAME OR SCHOOL NAME 				b. EMPLOYER'S NAME OR SCHOOL NAME 			
d. INSURANCE PLAN NAME OR PROGRAM NAME 				c. INSURANCE PLAN NAME OR PROGRAM NAME 			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____			
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 		17a. I.D. NUMBER OF REFERRING PHYSICIAN 		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. RESERVED FOR LOCAL USE 				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V70 0				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 			
2. _____ 3. _____ 4. _____				23. PRIOR AUTHORIZATION NUMBER 			
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY		B Place of Service		C Type of Service			
D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS CODE		F \$ CHARGES			
G DAYS OR UNITS		H EPSDT Family Plan		I EMG			
J COB		K RESERVED FOR LOCAL USE					
1 01 29 95 3 1 W7014 01 1 XX XX 1							
2 01 29 95 3 1 W7000 04 1 XX XX 1							
3 01 29 95 3 1 90701 1 XX XX 1							
4 01 29 95 3 1 W7020 1 XX XX 1							
5 01 29 95 3 1 90712 1 XX XX 1							
6 01 29 95 3 5 85018 1 XX XX 1							
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 1234JD		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I. M. Authorized SIGNED _____ MM/DD/YY		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I. M. Billing 1 W. Williams Anytown, WI 55555 PIN# _____ GRP# 87654321			